Unclassified
SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

(2)

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY N/A	3. DISTRIBUTION/AVAILABILITY OF REPORT Distribution Statement A: Approved for public release; distribution is unlimited.
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE N/A	
4. PERFORMING ORGANIZATION REPORT NUMBER(S) NDU-ICAF-93- F16	5. MONITORING ORGANIZATION REPORT NUMBER(S) Same
6a. NAME OF PERFORMING ORGANIZATION Industrial College of the Armed Forces 6b. OFFICE SYMBOL (If applicable) ICAF-FAP	7a. NAME OF MONITORING ORGANIZATION National Defense University
6c. ADDRESS (City, State, and ZIP Code) Fort Lesley J. McNair Washington, D.C. 20319-6000	7b. ADDRESS (City, State, and ZIP Code) Fort Lesley J. McNair Washington, D.C. 20319-6000
8a. NAME OF FUNDING/SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJEC NO.

AD-A278 182

11. TITLE (Include Security Classification)

Mobilizing Black America

12. PERSONAL AUTHOR(S) Michael E. FREEMAN

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Research	FROM Aug 92 TO Apr 93	April 1993	54

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

SEE ATTACHED

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☒ SAME AS RPT. ☐ DTIC USERS	Unclassified
22a. NAME OF RESPONSIBLE INDIVIDUAL Judy Clark	22b. TELEPHONE (Include Area Code) (202) 475-1889 / 22c. OFFICE SYMBOL ICAF-FAP

DD FORM 1473, 84 MAR 83 APR edition may be used until exhausted. All other editions are obsolete.

SECURITY CLASSIFICATION OF THIS PAGE

UNCLASSIFIED

ABSTRACT

Title: Mobilizing Black America

Author: Michael E. Freeman, Ltc., U.S. Army

Summary: The National Security Strategy is built on four pillars: Strategic Deterrence and Defense, Forward Presence, Crisis Response, and **Recontitution.** This paper was framed around the last pillar -- Reconstitution, while specifically addressing the tenet of mobilization with a focus on black Americans.

The Armed Forces of the U.S. are faced with drastic reductions, but must be prepared to go to war -- and win -- if the security of this nation is threaten. DoD must have all segments of society available for mobilization if additional personnel are required. Black Americans are an essential resource to be mobilized during reconstitution in preparation for a major conflict. I believe that black Americans will not be available in the future for mobilization due to a multitude of health problems in the black community,if these problems are not addressed today and are allowed to continue to deteriorate. The scope of this paper is limited to the following health issues. Access to Health Care, Infant Mortality, Homicides/Violence, and HIV/AIDS. The named health problem areas require immediate corrective action. I have recommended solutions and actions that would allow black Americans to be an available resource for mobilization in the future. All recommendations and actions require a concerted effort by congress, the federal government, the community, and the individuals affected.

1993
Executive Research Project
F16

Mobilizing Black America

Lieutenant Colonel
Michael E. Freeman
U.S. Army

Faculty Research Advisor
Dr. Alan L. Gropman

The Industrial College of the Armed Forces
National Defense University
Fort McNair, Washington, D.C. 20319-6000

1993
Executive Research Project
F16

Mobilizing Black America

Lieutenant Colonel
Michael E. Freeman
U.S. Army

Faculty Research Advisor
Dr. Alan L. Gropman

The Industrial College of the Armed Forces
National Defense University
Fort McNair, Washington, D.C. 20319-6000

DISCLAIMER

This research report represents the views of the author and does not necessarily reflect the official opinion of the Industrial College of the Armed Forces, the National Defense University, or the Department of Defense.

INDEX

MOBILIZING BLACK AMERICA

INTRODUCTION

The success of the military during the last forty years coupled with the collapse of the Warsaw Pact, the disintegration of the Soviet Union and other world events have created a changed world. Past events have caused the United States to reevaluate its National Security Strategy and its implementation in regards to our current and future National Security requirements.

> We must not lose sight of why we were successful. The strength of America and the Free World she leads is the reason for our success. Economic strength. Political strength. The strength of our values. And military strength.(1)

The National Security Strategy is built on four pillars: Strategic Deterrence and Defense, Forward Presence, Crisis Response, and Reconstitution. This paper will be framed around the last pillar--Reconstitution, while specifically addressing the tenet of mobilization.

Why Reconstitution? The ability to reconstitute for future conflicts is a must because of the limited number of forces that will be available. The current budget constraints and major force reductions in the Department of Defense (DOD) will have a drastic impact on future forces, based on the perceived threat or lack thereof. Reconstitution is the ability to mobilize resources, **personnel** and equipment in support of a conflict or future threat.

Why Mobilization? Mobilization is a term that has many different connotations. Harold J. Clem addresses mobilization in its purest sense as: "To the average citizen, it [mobilization] means getting the Country ready to fight a war. It is the process by which the might of a nation is brought to a state of readiness for armed conflict and includes assembling and organizing the personnel, material, supplies and the relevant and key production facilities to achieve a state of readiness."(2)

This paper "Mobilizing Black America" focuses on a single aspect of the process of reconstituting on a specific segment of America--black Americans. Black Americans are an essential resource to be utilized to reconstitute (expand) the ranks of the military services in preparation for or during a major conflict.

- o Does the current physical health of the black community enhance or impede the ability of the United States to mobilize this resource?
- o What is the true nature of the problem?
- o What is the role of Congress and other federal agencies regarding this matter?
- o If a problem exists, should/could the Defense Department have a role in solving this problem?

In order for the reader to better understand the magnitude of this potential problem and raise his/her consciousness, a significant amount of energy was devoted to identifying health issues that could destroy a valuable human resource - black Americans. This effort will also provide the reader a better appreciation for the recommended solutions.

There are many black related health issues that affect these questions. This paper will concentrate on only four main health issues facing the black community that require immediate attention if black Americans are to remain a viable resource when reconstitution is required:

- o Access to Health Care
- o Infant Mortality
- o Homicides/Violence
- o HIV/AIDS

Within this paper black Americans and Afro-Americans are used interchangeably.

BACKGROUND: IS THERE A DIFFERENCE IN HEALTH CARE IN DIFFERENT COMMUNITIES?

Since the African slave trade and the landing of black people in America in 1619, much has happened to Afro-Americans.(6) Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color or national origin. During the last 30 years many significant health care improvements have been made for all Americans although numerous studies have shown a disparity in health care being received by the minority - black Americans in the past few decades as compared to the health care being received by the majority - white Americans.

In 1964, Margaret M. Heckler, Secretary of Health and Human Services established a Task Force to investigate the magnitude of the disparity in the health status of minority groups compared with non-minorities, and its cause.

The standard frequently used to measure the quality of health care is the life expectancy and/or death rate and also "Excess Deaths". Excess Deaths - express the difference between the number of deaths actually observed in a minority group if it experienced the same death rate for each age and sex as the white population.(7)

The Task Force reported that in 1984, black Americans experienced 60,000 "excess deaths" each year. Six of the main causes of excess death were: cancer, heart disease and stroke, infant mortality, diabetes, homicide and unintentional injuries and chemical dependency. Today an additional major contributing factor is acquired immune deficiency syndrome.

In 1990, Dr. Louis W. Sullivan, Secretary of Health and Human Services stated, "Each year, there are almost 60,000 premature, excess deaths in our minority communities. And, most telling, black health status has not improved since 1984."(8)

Blacks make up more than 12 percent of the population of the United States, approximately 30 million people. The gap in life expectancy has widened over the years. For both blacks and whites the total number of females exceeds the total number of males in the over-all population (Table 1). Worthy of note here is that the numbers show that for blacks up to age 24, males exceed females. Among whites that trend does not occur until age 54.

In 1989, life expectancy for white females at birth was 79.2 years; black females 73.5 years; white males 72.7; and black males 64.8.(9) Note in 1985 the life expectancies for black males began to decline while all other groups increased (Table 2).

TABLE 1

Population Distribution, by Race, Sex, and Age, 1988

	Blacks		Whites	
Age	Males	Females	Males	Females
Less than 1 year	300	293	1,599	1,517
1-4 years	1,123	1,086	6,031	5,732
5-14 years	2,739	2,656	14,296	13,552
15-24 years	2,712	2,781	15,478	15,065
25-34 years	2,598	2,906	18,491	18,126
35-44 years	1,736	2,074	15,063	15,134
45-54 years	1,145	1,412	10,240	10,600
55-64 years	969	1,170	9,087	10,064
65-74 years	660	886	7,124	8,867
75-84 years	272	454	3,240	5,389
85 years +	70	158	739	1,940
Total	14,325	15,877	101,389	105,988

Source: *Health, United States*, 1990. Hyattsville, MD: Public Health Service.

TABLE 2

Life Expectancy at Birth*, by Race and Sex, 1950-1988

Years	Blacks		Whites	
	Males	Females	Males	Females
1950	58.9	62.7	66.5	72.2
1960	60.7	65.9	67.4	74.1
1970	60.0	68.3	68.0	75.6
1975	62.4	71.3	69.5	77.3
1980	63.8	72.5	70.7	78.1
1981	64.5	73.2	71.1	78.4
1982	65.1	73.7	71.5	78.7
1983	65.4	73.6	71.7	78.7
1984	65.6	73.7	71.8	78.7
1985	65.3	73.5	71.9	78.7
1986	65.2	73.5	72.0	78.8
1987	65.2	73.6	72.2	78.9
1988	64.9	73.4	72.3	78.9

*For example, a black male born in 1980 could expect to live 63.8 years.
Source: *Health, United States*, 1990. Hyattsville, MD: Public Health Service.

The numbers show very vividly that fewer males will be an available resource in the future if the current trend continues among blacks between the ages of 17 and 41.

It is believed by some that "the condition of an individual's health is the result of three forces: heredity, environment, and behavior. Of these three forces the individual has the most control over behavior.(7) Another study shows that the current state of health care is a general reflection of society which is impacted by social, economic and political factors. These factors are further explained in terms of: institutional racism, economic inequality and access barriers.

The Department of Defense has always had a genuine concern for the health and wealth of its personnel. The Secretary of Defense is required to submit an Annual Defense Report to fulfill the requirements of Section 113(c) and (e) of Title 10 of the United States Code and Section 405 of the Department of Defense Reorganization Act of 1986 (Public Law 99-433).(10) Within the February 1992 Annual Report the Secretary of Defense addressed under Defense Resources Personnel (Manpower and Health).

During FY 1990, the Department devoted 157,000 military personnel, 52,000 civilian personnel and $14 billion to its medical functions.(5) When the Secretary of Defense prepared the report he was concerned with inefficiencies in the system, cost control and access to medical care and how they will impact on successful recruitment and retention of personnel. It must be noted here that the Secretary's primary concern is for the personnel in or related to DOD. Although the focus on DOD is admirable, it is too narrow in scope. The focus does not show an interest in society in total but only one small segment of society. It is anticipated that in the future there will be a greater need for mobilization and those available will have greater health problems.

As of 31 December 1991, the active duty forces were 1,943,937; guard and reserve were 1,806,092; and civilian employees were 1,007,132. Black Americans in uniform total 397,064 which equals about 20.4 percent of the active duty force. The numbers presented are from the Defense 92 Almanac.

ACCESS TO HEALTH CARE: DOES EVERYONE HAVE EQUAL ACCESS?

Access to quality health care is a major concern of the majority of Americans. The issue of health care and lack thereof is multiplied in the black community as a result of poverty, racial bias, lack of black physicians and limited access to quality health care. The Journal of the American Medical Association (JAMA) reported in 1986 that "blacks compared with whites are less likely to be satisfied with qualitative ways their physicians treat them when they are ill, more dissatisfied with the care they receive when hospitalized, and more likely to believe that the duration of their hospitalization is too short."

Health care can most often be related to income. When those needing health care fail to visit physicians on a frequent basis -preventive maintenance in a sense - they will begin treatment in a much later stage of an illness. The following table (3) shows that 50% of blacks are seen in a physician's office but one-fifth are seen in hospital outpatient departments.

POVERTY

Throughout history, higher death rates have always been associated with those on the lower end of the socioeconomic ladder. According to a 1989 Census Bureau Report in 1987, 31.8 percent of Afro-American families were living below the poverty line and only 9.1 percent of white families. 51.3 percent of Afro-American families were married couples compared to 83.2 percent of white families; 35.4 percent were headed by females compared to 12.9 percent for whites. The statistics show that, although progress has been made over the years, blacks still lag significantly behind. The following table (4) vividly shows the gap as of 1987.

The aforementioned information serves as indicators of family structure which directly impacts on the financial status of the family unit. The cycle of poverty is a vicious one and very difficult to break.

TABLE 3

Physician Contacts, by Place of Contact and Race, 1989

Percent of Contacts

	Race	
	Blacks	Whites
Physician's Office	50.6	60.9
Hospital Outpatient Department	20.4	12.2
Telephone	9.3	12.9
Home	2.0	1.4
Other	17.8	12.7

Source: *Health, United States*, 1990. Hyattsville, MD: Public Health Service.

TABLE 4

Measures of Socioeconomic Status, by Race, 1987.

	African-American	*White*
Median years of education	12.3	12.7
Percent completing high school		
Males	63.0	76.5
Females	63.7	75.9
Percent completing college		
Males	11.0	24.5
Females	10.4	16.9
Median household income		
All households	$18,098	$32,529
Those below poverty	$5,419	$5,908
Occupation		
Managerial/professional	14.9	29.0
Technical	22.7	22.5
Service	24.1	8.2

Source: Data extracted from U.S. Bureau of the Census, 1988, Table 12, p. 74; 1989b, Table 16, pp. 60–87.

RACISM

The health care system is a product of our total environment and racial disparities here are a reflection of our society, however, significant improvements have been made in the delivery of health care. Differences in income and education do exist, but once these factors are removed from the equation, blacks still receive health care less frequently than that of whites. It must be understood that racism today is an extension of the long history of black and white relations.

Racism most often is reflected in the manner doctors treat patients - sincerity of doctor-patient relationships; implementation of policies and their fairness; admission practices of hospitals; the duration of stays in the hospital; and the duration and/or treatment for like illness. Many of the numbers that will be addressed support the notion of racism.

HEALTH INSURANCE

Medicare and Medicaid, enacted in 1965 by the federal government, provides health insurance for many. The overall implementation of the programs may vary from state to state due to eligibility requirements. One study showed that 17.1% of blacks and 4.5% of whites were covered by Medicaid (Table 5). Medicaid has been a significant source for accessing health care, but it is also obvious that blacks are disproportionately represented. Even with Medicaid many blacks (one-fifth) are without insurance. There is also concern that Medicaid probably provides inadequate access to inpatient care as a result of funds received for services.

TABLE 5

Health Insurance Coverage for Persons Under Age 65, by Race, 1989

Percent of Population

Type of Insurance	Race	
	Blacks	Whites
Private Insurance	59.2	79.7
Medicaid	17.1	4.5
Not Covered	22.0	14.5

Source: *Health, United States*, 1990. Hyattsville, MD: Public Health Service.

BLACK PHYSICIANS

Another significant reason for the disparity in health care is the lack of the availability of black physicians. The 1980 census showed that there were over 400,000 physicians in the U.S., and less than 3% were Black. Most recently the National Science Foundation stated that there are only approximately 16,000 black doctors.

The education of black physicians is important because a much greater number of these physicians return to the black community to practice medicine. A large number of minority physicians can impact directly on social problems through their practice patterns. The black physician in the community fulfills many needs, i.e., role model, a trusted figure within the system, an educator and a catalyst for improving the quality of health care while reducing barriers to access quality health care. The black physician in the community processes the ability to begin destroying the "two-tiered" health care system that serves the affluent and neglects the poor, as described by Dr. Braithwaite of Morehouse School of Medicine.(13)

SUMMARY

Significant improvements in access to health care have been made over the last 30 years. Much work remains in closing the gap that exists between the health status of whites and blacks. Easy access to medical care must be made available to all segments of society. The poor as well as the wealthy have a need and right to quality medical care. The medical community must aggressively attempt to eliminate racial prejudice from the system and foster a bond of trust between the doctor and patient.

INFANT MORTALITY: WHY ARE THEY DYING SO YOUNG?

> The birth of a healthy infant to a healthy woman is the most important goal of our nation.(16)

Infant mortality is defined by the Human Health Services as the number of children out of every 1,000 born who do not reach their first birthday. A review of any data available on this subject shows that in the U.S. black infants die at twice the rate of white infants during the first year. Table 6 shows that in 1989 the infant death rate for blacks was 18.6 per 1000 live births as compared to 8.1 for white live births. In 1981 the United States ranked sixth in infant mortality among developed countries. In a March 1991 speech, the Secretary of Health and Human Services stated that the U.S. was now number twenty-three in infant mortality rates.

TABLE 6

Infant Mortality Rate, by Race, 1950-1989

Years	Total	Race	
		Blacks	Whites
1950	29.2	43.9	26.8
1960	26.0	44.3	22.9
1970	20.0	32.6	17.8
1980	12.6	21.4	11.0
1981	11.9	20.0	10.5
1982	11.5	19.6	10.1
1983	11.2	19.2	9.7
1984	10.8	18.4	9.4
1985	10.6	18.2	9.3
1986	10.4	18.0	8.9
1987	10.1	17.9	8.6
1988	10.0	17.6	8.5
1989	9.8	18.6	8.1

Source: *Health, United States*, 1990 (Hyattsville, MD: Public Health Service) and *Monthly Vital Statistics Report*, January 7, 1992 (Hyattsville, MD: Public Health Service).

The 1984 Task Force on Black and Minority Health found that 60% of infant deaths was a result of low birth weight. Low birth weight today is a major contributor to the high infant death rate. Low birth weight is considered as weighing less than 2,500 grams or 5 pounds 8 ounces.

There are several causes of infant mortality. When discussing this subject it is more specifically spoken of in terms of neonatal and post-natal mortality. Neonatal mortality refers to deaths within the first 28 days of life. Postneonatal mortality refers to those deaths that occur from 28 days to 1 year after birth.(7) The 1984 Task Force Study found that postneonatal death rates were higher among blacks for all major causes of death except congenital anomalies, or birth defects.

The four leading causes of infant death were:

- o Congenital anomalies
- o Sudden infant death syndrome
- o Disorders relating to short gestations unspecified low birth weight
- o Respiratory distress syndrome

The above causes of death accounted for over 54 percent of all infant deaths in 1989.(17)

Congenital anomalies accounted for the majority of white deaths followed by sudden infant death syndrome. Different causes of death were found in the black community; unspecified low birth weight and disorders relating to short gestation followed by sudden infant death syndrome were the leading causes. Table 7 contains a complete list of causes of infant death and Table 8 provides the top ten causes of infant deaths.

ASSOCIATED RISK FACTORS

There are many contributing factors that impact directly on the high infant mortality rates experienced in the U.S. The common thread that is interwoven throughout all segments of society were social and economic factors, which range from the mother's health status to her income. The next paragraphs will narrow the scope of this discussion to prenatal care, adolescent pregnancies, and education as contributing factors to low birthweight.

- Prenatal Care

In 1987, 74,087 pregnant women were without prenatal care in this country and more than one-third - 26,743 were black women. In the black community 38.9 percent of women didn't receive prenatal care during the first trimester of pregnancy compared to 20.6 percent of white women. Lack of medical insurance and the financial status of pregnant women serve as major obstacles to obtaining adequate prenatal care.

TABLE 7

Deaths under 1 year and infant mortality rates for 61 selected causes by race: United States, 1989

(Rates per 100,000 live births in specified group. For explanation of asterisk preceding cause-of-death codes, see Technical notes. Beginning in 1989, race for live births is tabulated according to race of mother; see Technical notes)

Cause of death (Ninth Revision International Classification of Diseases, 1975)		All races[1]	White	Black	All races[1]	White	Black
		Number			Rate		
All causes		39,665	25,794	12,527	981.3	808.0	1,661.0
Certain infectious and parasitic diseases	001-009	92	38	49	2.3	1.2	6.4
Whooping cough	033	9	7	2	*	*	*
Meningococcal infection	036	58	43	12	1.4	1.3	*
Septicemia	038	290	173	110	7.2	5.4	14.3
Viral diseases	045-079	139	89	40	3.4	2.8	5.2
Congenital syphilis	090	19	4	15	*	*	*
Remainder of infectious and parasitic diseases	001,007,010-032,034-035, 037,039-041,*042-*044,080-088,091-139	274	143	124	6.8	4.5	16.4
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	140-208	107	92	15	2.6	2.9	*
Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature	210-239	58	39	15	1.4	1.2	*
Diseases of thymus gland	254	6	5	–	*	*	*
Cystic fibrosis	277.0	15	11	4	*	*	*
Diseases of blood and blood-forming organs	280-289	90	48	33	2.2	1.5	4.8
Meningitis	320-322	229	128	87	5.7	4.0	12.8
Other diseases of nervous system and sense organs	323-389	492	383	109	12.2	11.4	16.2
Acute upper respiratory infections	460-466	34	29	4	0.8	0.9	*
Bronchitis and bronchiolitis	466,490-491	103	58	37	2.5	1.8	5.5
Pneumonia and influenza	480-487	636	398	210	15.7	12.4	31.2
Pneumonia	480-486	624	388	208	15.4	12.1	30.9
Influenza	487	12	10	2	*	*	*
Remainder of diseases of respiratory system	470-478,488-519	384	230	139	9.5	7.2	20.8
Hernia of abdominal cavity and intestinal obstruction without mention of hernia	550-553,560	86	57	27	2.2	1.8	4.0
Gastritis, duodenitis, and noninfective enteritis and colitis	535,555-558	100	48	51	2.5	1.5	7.6
Remainder of diseases of digestive system	520-534,536-543,562-579	171	98	69	4.2	3.0	10.3
Congenital anomalies	740-759	8,139	6,312	1,498	200.9	197.7	222.5
Anencephalus and similar anomalies	740	469	367	98	11.4	12.1	6.5
Spina bifida	741	73	63	7	1.8	2.0	*
Congenital hydrocephalus	742.3	172	119	44	4.3	3.7	6.5
Other congenital anomalies of central nervous system and eye	742.0-742.2,742.4-742.9,743	314	244	54	7.8	7.6	8.0
Congenital anomalies of heart	746-747	2,589	1,983	479	63.3	62.1	71.2
Other congenital anomalies of circulatory system	747	491	354	124	12.2	11.1	18.4
Congenital anomalies of respiratory system	748	1,256	954	261	31.1	29.9	38.8
Congenital anomalies of digestive system	749-751	111	82	26	2.7	2.6	3.9
Congenital anomalies of genitourinary system	752-753	473	388	77	11.7	12.2	11.4
Congenital anomalies of musculoskeletal system	754-756	543	431	92	13.4	13.5	13.7
Down's syndrome	758.0	93	72	18	2.3	2.3	*
Other chromosomal anomalies	758.1-758.9	897	713	135	22.2	22.3	20.1
All other and unspecified congenital anomalies	744,757,759	478	322	125	11.8	10.1	18.6
Certain conditions originating in the perinatal period	760-779	18,394	11,181	6,907	456.4	350.2	1,028.1
Newborn affected by maternal conditions which may be unrelated to present pregnancy	760	199	104	87	4.9	3.3	12.9
Newborn affected by maternal complications of pregnancy	761	1,534	987	518	38.0	30.9	76.7
Newborn affected by complications of placental, cord, and membranes	762	984	672	288	24.4	21.1	42.8
Newborn affected by other complications of labor and delivery	763	68	41	24	1.7	1.3	3.6
Slow fetal growth and fetal malnutrition	764	30	22	7	0.7	0.7	*
Disorders relating to short gestation and unspecified low birthweight	765	3,931	1,961	1,867	97.3	62.1	277.4
Disorders relating to long gestation and high birthweight	766	1	1	–	*	*	*
Birth trauma	767	222	147	70	5.5	4.6	10.4
Intrauterine hypoxia and birth asphyxia	768	725	466	227	17.9	14.6	33.7
Fetal distress in liveborn infant	768.2-768.4	193	131	50	4.8	4.1	7.4
Birth asphyxia	768.5-768.9	532	335	177	13.2	10.5	26.3
Respiratory distress syndrome	769	3,631	2,384	1,159	89.9	74.7	172.2
Other respiratory conditions of newborn	770	3,344	2,013	1,238	82.8	63.1	183.9
Infections specific to the perinatal period	771	892	571	300	22.1	17.9	44.6
Neonatal hemorrhage	772	263	168	89	6.5	5.3	13.2
Hemolytic disease of newborn, due to isoimmunization, and other perinatal jaundice	773-774	37	22	15	0.9	0.7	*
Syndrome of "infant of a diabetic mother" and neonatal diabetes mellitus	775.0-775.1	10	8	2	*	*	*
Hemorrhagic disease of newborn	776.0	3	–	3	*	*	*
All other and ill-defined conditions originating in the perinatal period	775.2-775.9,776.1-779	2,680	1,594	1,015	66.8	49.9	150.8
Symptoms, signs, and ill-defined conditions	780-799	6,627	4,323	2,017	164.0	135.4	299.6
Sudden infant death syndrome	798.0	5,634	3,773	1,617	139.4	118.2	240.2
Symptoms, signs, and all other ill-defined conditions	780-797,798.1-799	993	550	400	24.6	17.2	59.4

See footnote at end of table

TABLE 8

Deaths under 1 year and infant mortality rates for the 10 leading causes of infant death: United States, 1989

[Rates per 100,000 live births. Beginning in 1989, race for live births is tabulated according to race of mother; see Technical notes]

Rank order[1]	Cause of death (Ninth Revision International Classification of Diseases, 1975)		Number	Rate
		All races[2]		
...	All causes		39,655	981.3
1	Congenital anomalies	740–759	8,120	200.9
2	Sudden infant death syndrome	798.0	5,634	139.4
3	Disorders relating to short gestation and unspecified low birthweight	765	3,931	97.3
4	Respiratory distress syndrome	769	3,631	89.9
5	Newborn affected by maternal complications of pregnancy	761	1,534	38.0
6	Accidents and adverse effects	E800–E949	996	24.6
7	Newborn affected by complications of placenta, cord, and membranes	762	984	24.4
8	Infections specific to the perinatal period	771	892	22.1
9	Intrauterine hypoxia and birth asphyxia	768	725	17.9
10	Pneumonia and influenza	480–487	636	15.7
...	All other causes	Residual	12,572	311.1
		White		
...	All causes		25,794	808.0
1	Congenital anomalies	740–759	6,312	197.7
2	Sudden infant death syndrome	798.0	3,773	118.2
3	Respiratory distress syndrome	769	2,384	74.7
4	Disorders relating to short gestation and unspecified low birthweight	765	1,981	62.1
5	Newborn affected by maternal complications of pregnancy	761	987	30.9
6	Newborn affected by complications of placenta, cord, and membranes	762	672	21.1
7	Accidents and adverse effects	E800–E949	614	19.2
8	Infections specific to the perinatal period	771	571	17.9
9	Intrauterine hypoxia and birth asphyxia	768	466	14.6
10	Pneumonia and influenza	480–487	396	12.4
...	All other causes	Residual	7,638	239.3
		Black		
...	All causes		12,527	1,881.0
1	Disorders relating to short gestation and unspecified low birthweight	765	1,857	277.6
2	Sudden infant death syndrome	798.0	1,617	240.2
3	Congenital anomalies	740–759	1,498	222.5
4	Respiratory distress syndrome	769	1,159	172.2
5	Newborn affected by maternal complications of pregnancy	761	516	76.7
6	Accidents and adverse effects	E800–E949	335	49.8
7	Infections specific to the perinatal period	771	300	44.6
8	Newborn affected by complications of placenta, cord, and membranes	762	288	42.8
9	Intrauterine hypoxia and birth asphyxia	768	227	33.7
10	Pneumonia and influenza	480–487	210	31.2
...	All other causes	Residual	4,510	670.0

[1] Rank based on number of deaths; see Technical notes.

[2] Includes races other than white and black.

Due to the lack of prenatal care to the economically deprived mothers many fail to modify their lifestyle in terms of diet and behavior. Too often many are ill-prepared mentally, physically and financially for childbirth or parenting.

- Adolescent Pregnancy

Black female teenagers 15 to 19 years old were 140 percent more likely to have a child than a white teenager in 1987. Also in that year white teenagers of the same age group had 7.7 percent low birthweight babies compared to blacks who had 13.1 percent of low birthweight babies.(19) Another study included in the Health Department's report implied that the following factors are normally associated with low birthweight infants of adolescent mothers:

- o Poor nutrition
- o Increased substance abuse
- o Increased frequency of genital infections
- o Less access to prenatal care

Table 9 shows that many low birthweight infants are born to unwed poor mothers. In 1987 more than three in five (62.2 percent) among black females were born out of wedlock compared to one in six among white females (16.7 percent).

Many poor black adolescents fail to see the long term impact of having a child or children at an early age. They often see their future as being the same tomorrow as it was yesterday - no hope for improvement, so they are unable to imagine how a child born out of wedlock can change their entire future.

TABLE 9

Percent of live births, by race of child and selected characteristics: United States, selected years 1970–1987

Race of child and characteristic	Percent of births									
	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
All races										
Birth weight: [1]										
Less than 2,500 grams	7.94	7.39	6.84	6.81	6.75	6.82	6.72	6.75	6.81	6.90
Less than 1,500 grams	1.17	1.16	1.15	1.16	1.18	1.19	1.19	1.21	1.21	1.24
Age of mother:										
Less than 18 years	6.3	7.6	5.8	5.4	5.2	5.0	4.8	4.7	4.8	4.8
18–19 years	11.3	11.3	9.8	9.4	9.0	8.7	8.3	8.0	7.8	7.6
Unmarried mothers	10.7	14.3	18.4	18.9	19.4	20.3	21.0	22.0	23.4	24.5
Education of mother:										
Less than 12 years	30.8	26.6	23.7	22.9	22.3	21.7	20.9	20.6	20.4	20.2
16 years or more	8.6	11.4	14.0	14.8	15.3	15.9	16.4	16.7	17.1	17.6
Prenatal care began:										
1st trimester	68.0	72.4	76.3	76.3	76.1	76.2	76.5	76.2	75.9	76.0
3rd trimester or no prenatal care	7.9	6.0	5.1	5.2	5.5	5.6	5.6	5.7	6.0	6.1
White										
Birth weight: [1]										
Less than 2,500 grams	6.84	6.26	5.70	5.67	5.63	5.67	5.59	5.64	5.64	5.68
Less than 1,500 grams	0.95	0.92	0.90	0.90	0.92	0.93	0.92	0.94	0.93	0.94
Age of mother:										
Less than 18 years	4.8	6.0	4.5	4.3	4.1	3.9	3.7	3.7	3.7	3.7
18–19 years	10.4	10.3	9.0	8.6	8.2	7.9	7.4	7.1	6.9	6.8
Unmarried mothers	5.7	7.3	11.0	11.6	12.1	12.8	13.4	14.5	15.7	16.7
Education of mother:										
Less than 12 years	27.0	25.0	20.7	19.9	19.3	18.7	18.0	17.8	17.6	17.3
16 years or more	9.5	12.7	15.6	16.4	17.0	17.7	18.4	18.7	19.2	19.9
Prenatal care began:										
1st trimester	72.4	75.9	79.3	79.4	79.3	79.4	79.6	79.4	79.2	79.4
3rd trimester or no prenatal care	6.2	5.0	4.3	4.3	4.5	4.6	4.7	4.7	5.0	5.0
Black										
Birth weight: [1]										
Less than 2,500 grams	13.86	13.09	12.49	12.53	12.40	12.59	12.36	12.42	12.53	12.71
Less than 1,500 grams	2.40	2.37	2.44	2.47	2.51	2.55	2.56	2.65	2.66	2.73
Age of mother:										
Less than 18 years	14.7	16.1	12.2	11.4	11.1	10.9	10.6	10.3	10.4	10.5
18–19 years	16.6	16.8	14.3	13.9	13.5	13.4	13.1	12.7	12.4	12.1
Unmarried mothers	37.4	49.0	55.2	56.0	56.7	58.2	59.2	60.1	61.2	62.2
Education of mother:										
Less than 12 years	51.0	45.1	36.2	35.4	34.8	34.2	33.1	32.3	31.7	31.4
16 years or more	2.8	3.4	6.3	6.6	6.8	6.8	7.0	7.1	7.3	7.2
Prenatal care began:										
1st trimester	44.4	55.8	62.7	62.4	61.5	61.5	62.2	61.8	61.6	61.1
3rd trimester or no prenatal care	16.6	10.5	8.8	9.1	9.6	9.7	9.6	10.0	10.6	11.1

[1] Before 1979, data are for infants weighing 2,500 grams or less at birth.
[2] Includes Chinese, Japanese, Filipino, Hawaiian (includes part Hawaiian), Guamanian (1970 and 1975), and other Asian or Pacific Islander (starting in 1990).
[3] Includes Aleut and Eskimo.

Note: Data on education of mother are not available from California, Texas, and Washington. Other States do not have data on marital status, education, and/or month prenatal care began for certain years before 1980.

Sources: (1) National Center for Health Statistics, Health, United States 1988, Mar. 1989. Department of Health and Human Services, Pub. No. (PHS) 89-1232. Hyattsville, MD, Table 7, p. 47; (2) National Center for Health Statistics, Monthly Vital Statistics Report, Advance Report of Final Natality Statistics, 1987, Vol. 38, No. 3, Supplement, Jun. 29, 1989, Hyattsville, MD, Table 2, p. 16, Table 15, pp. 28–29, Table 18, p. 32, Table 21, p. 36, Tables 28 & 29, p. 40, Table 30, p. 41; and (3) Unpublished data from National Center for Health Statistics.

- Education

> The risk of low birthweight continues to be considerably less for babies born to better educated mothers, regardless of race.(19)

The results of a lack of education is far reaching and one aspect is reflected in the low birthweight statistics. The frequency of low birthweight babies being born can partially be attributed to the lack of health education and failure to adhere to good health practices before, during and after childbearing. Some reports suggest that although years of education may be equal all other factors that make up our environment are not.

SUMMARY

Infant mortality is a terrible waste of a life and a very poor reflection on our health care system. Over the last ten years very little progress has been made in reducing the percentage of low birthweight babies. The lack of education, the non-availability of prenatal care combined with a dim view for the future has created a very harsh outlook for poor pregnant mothers. The solution to this problem must include all elements of the environment ranging from the individual to the care providers and the government which assists in developing and funding an infrastructure.

HOMICIDES/VIOLENCE: ARE THESE SELF-INFLICTED WOUNDS?

Homicide is more than a criminal justice problem. Because death rates from homicide are so high in the United States, it has been recognized as a public health problem. Homicide differs from other health problems because it is the result of a conscious mental process that impacts more than just the individual.(21) The number of deaths resulting from homicide/violence in the black community is devastating and of major concern. This activity is consuming large numbers of blacks during the prime of their lives - when they should be preparing to become assets in the community. A very large percentage of homicides are black-on-black. The deaths of black males has created a homicide rate four to five times greater than their white counterparts. Tables 10 and 11 support these facts. This violence in the black community is a major cause in the number of living black males being smaller than those of living black females in the age group 15-34 as presented earlier in this paper.

RISK FACTORS

A large number of violent crimes and homicides are rooted in the environment, social and psychological. The following list of risk factors are self-explanatory:

- o Low economic status
- o Family structure
- o Violence in the home
- o Lack of problem resolving skills
- o Availability of weapons
- o Low value for life
- o Alcohol and drug abuse

TABLE 10

Death Rates Due to Homicide, by Race, Sex, and Age, 1988

Per 100,000 Population

	Blacks		Whites	
Age	Males	Females	Males	Females
Less Than 1 year	19.3	23.5	5.6	6.0
1-4 years	7.5	6.3	2.2	1.6
5-14 years	4.2	3.1	1.0	0.8
15-24 years	101.8	17.4	11.5	3.9
25-34 years	108.8	25.5	13.2	4.4
35-44 years	79.2	14.6	10.4	3.2
45-54 years	45.2	7.7	7.6	2.5
55-64 years	29.1	6.8	6.0	2.0
65-74 years	26.2	9.0	4.1	2.3
75-84 years	30.5	9.9	4.3	3.0
85 years and over	31.4	12.7	5.1	2.9

Source: *Health, United States*, 1990. Hyattsville, MD: Public Health Service.

TABLE 11

Homicide Victims, by Race and Sex: 1970 to 1988

[Rates per 100,000 resident population in specified group. Beginning 1970, excludes deaths to nonresidents of U.S. Beginning 1980, deaths classified according to the ninth revision of the *International Classification of Diseases;* for earlier years, classified according to revision in use at the time; see text, section 2. See also *Historical Statistics, Colonial Times to 1970*

YEAR	HOMICIDE VICTIMS					HOMICIDE RATE [2]				
	Total [1]	White		Black		Total [1]	White		Black	
		Male	Female	Male	Female		Male	Female	Male	Female
1970	16,848	5,865	1,938	7,265	1,569	8.3	6.8	2.1	67.6	13.3
1975	21,310	8,222	2,751	8,092	1,929	9.9	9.0	2.9	69.0	14.9
1980	24,278	10,381	3,177	8,385	1,898	10.7	10.9	3.2	66.6	13.5
1981	23,646	9,941	3,125	8,312	1,825	10.3	10.4	3.1	64.8	12.7
1982	22,358	9,260	3,179	7,730	1,743	9.6	9.6	3.1	59.1	12.0
1983	20,191	8,355	2,880	6,822	1,672	8.6	8.6	2.8	51.4	11.3
1984	19,796	8,171	2,956	6,563	1,677	8.4	8.3	2.9	48.7	11.2
1985	19,893	8,122	3,041	6,616	1,666	8.3	8.2	2.9	48.4	11.0
1986	21,731	8,567	3,123	7,634	1,861	9.0	8.6	3.0	55.0	12.1
1987	21,103	7,979	3,149	7,518	1,969	8.7	7.9	3.0	53.3	12.6
1988	22,032	7,994	3,072	8,314	2,089	9.0	7.9	2.9	58.0	13.2

[1] Includes races not shown separately. [2] Rate based on enumerated population figures as of April 1 for 1960, 1970, and 1980; July 1 estimates for other years.

Source: U.S. National Center for Health Statistics, *Vital Statistics of the United States*, annual.

VICTIMS

Dr. Sullivan, Secretary of Health and Human Services, said in a March 1991 speech,

> The leading killer of young black males is young black males.(5)

In 1987, the Federal Bureau of Investigation showed that 95 percent of black homicides were committed by black perpetrators. Most often homicide victims knew their assailants in 58.3 percent of the cases and over three-fourths of the men knew their assailants as friends or acquaintances. Black females that fell victim knew their assailants in 65.8 percent of the cases and in 43.8 percent of those homicides the assailants were family members.(22) Incidents of gang violence have not been a significant factor in the past but it is anticipated that a combination of gang violence and drug-related crimes will begin to cause a significant number of homicides.

IMPACT

Homicides and violence in the black community or in any community has a three-fold impact in the following areas:

- o Society - the loss of the victim and his potential contributions to society.
- o Family - the emotional pain experienced by the survivor's family and their loss of a family member.

o Individual - the potential loss of the perpetrator, the individual will more than likely receive a police record and/or prison time which in turn will seriously limit his potential to become an asset to society; and increases his chances of becoming a liability in society, a possible criminal.

SUMMARY

Black on black deaths are reaching an epidemic rate. This health problem requires a greater effort from the Department of Health and Human Services at looking pass the end results - statistics and getting to the root of the problem. A solution to this problem will require a concerted effort that includes the community, parents and individuals.

HIV/AIDS: WHO DOES IT AFFECT MOST?

The Center for Disease Control (CDC) shows that blacks constitute 12 percent of the total population but constitute 28 percent of all Americans with AIDS. Fifty-three percent of all children under 13 years of age with AIDS in American are black. With these high numbers it is easy to see that the black family is being hard hit with this disease in addition to the problems they already face; low income, separation, divorce and homes headed by single parents.

Human Immunodeficiency Virus (HIV) destroys the white blood cells (T-Lymphocytes) of a person's immune system, making him or her vulnerable to infections that may cause life threatening illnesses. Acquired Immune Deficiency Syndrome (AIDS) is a disease caused by the human immunodeficiency virus which is transmitted in the semen, vaginal discharge, blood or breast milk of HIV infected people.

The first known case of AIDS was recorded in June 1981 by the CDC. Since that date AIDS has been spreading like an epidemic in the black community. As early as 1982 with 250 cases reported, data suggested that blacks may have been at a higher risk for the disease. The ratio of AIDS cases reported by the CDC per population among blacks was about 3.1 times higher than among whites. Those ratios remained about the same for males (3.1) in 1991, (see table 12). Even with the high initial figures the first national conference on AIDS in the minority communities was not sponsored until August 1987. This conference was an official acknowledgement that the HIV/AIDS epidemic disproportionately affected the black community.

In 1991, 182,834 cases of AIDS were reported in the United States. The ratio had grown to 3.5 blacks being more likely to contract AIDS than whites. One study conducted based on the number of cases in 1981 and the increase in cases by quarter suggest that by 1994 there will be 600,000 AIDS cases in the black community, and short of a medical breakthrough over a million cases of AIDS in the black community by 1995.(18)

TABLE 12

AIDS Rates and Ratios for Blacks and Whites, U.S. 1991.

	Rates		
	Black	*White*	*Ratios*
Male	2.69	0.86	3.13
Female	0.55	0.04	13.75
Children	0.22	0.02	12.76

Source: Adapted from Centers for Disease Control, 1990a.

TRANSMISSION

The greatest disproportion of AIDS cases in the black community are among women and children, (See Table 12). Half of all AIDS cases among women are black and half are also intravenous (IV) abusers. The obvious cause of the high incidence of AIDS in black children are their mothers. Studies have shown that the three leading causes of AIDS among black women are:

- o Intravenous drug abuse
- o Risk behavior of the woman
- o Risk behavior of their sex partners

For far too long the black community has held myths about the transmission of AIDS, thinking that it was a "gay white man's disease" and "it could never happen to me." The myths combined with the heavy drug use in the community has had an overwhelming sad result. The dependency on drugs, ranging from alcohol to crack, causes the users to throw caution and reason out of the window.

SUMMARY

AIDS is rapidly eating away at the heart of the black community - the family. Currently there is no cure for this dreadful disease; therefore, the disease victims will continue to grow unless there is a drastic change in behavior, aiming at prevention.

CONCLUSION: THE PRESENT

To return to my initial thesis question: Does a Problem Exist In the Black Community That Could Preclude This Resource From Being Mobilized?

The undisputed truth is YES, the current status of health care in the black community could result in Afro-Americans not being available for mobilization during

periods of reconstitution. The number of black Americans that are dying as a result of the country's current health care system coupled with the failure of individuals to take responsibility has resulted in over 60,000 excess deaths per year, and this number has probably risen over the last few years. Whatever the number is, 60,000+ is too high even in a prudent man's view - these numbers represent a grave tragedy and significant lost to society - something must be done to reduce these numbers.

This paper limited its scope to health care in the black community with a specific focus on:

- o Access
- o Infant Mortality
- o Homicide/Violence
- o HIV/AIDS

These areas were chosen because they reflect the earliest and most immediate impact on social and economic conditions of the environment. A comparison of black and white racial groups was used to identify health disparities between races.

Access to quality health care should be a right for all Americans and not a privilege reserved for the affluent. Indeed health care access is restricted and influenced by such factors as low or no income resulting in poverty; the remains of racism lingering among some health care providers; the lack of the availability of health care insurance for all; and the constantly diminishing number of Afro-American physicians available to work in the black community. These factors and many others have resulted in blacks failing to participate in preventive or corrective (maintenance) health care in the numbers necessary to make a difference and has slowly eroded the little trust and confidence blacks had in the system.

The Afro-American's **infant mortality** rate of twice that of white's is frightening, an entire generation suffering severe casualties before they even get started. The health status of mothers, physical and mental, is a key factor in this problem. The problems surrounding low birth weight babies in most cases can be traced to the mother's education level, her marital status and income, availability of prenatal and postnatal health care and lifestyle. Studies have shown that the less formal education a mother has the greater the risk of having a low birth weight baby. Often in the black community young unwed teenagers are becoming pregnant, which directly impacts on them acquiring a formal education and also their future earning potential and ability to purchase health insurance. As a result young mothers fail to seek out proper prenatal care and harbor many myths regarding childbearing and available assistance.

Homicide and violence are the leading killers of Afro-American men in the prime of their life (ages 15-34). This age group contains the target age (17-34) that would be considered for mobilization. The magnitude of this problem is probably significantly greater than the numbers reflect. Excluded from the violent crime data were statistics from school data, emergency rooms, and police. In many cases, violence starts at home and spreads abroad (into the community). Once again, income and family structure play an important role in the number of homicides and incidents of crime.

HIV and AIDS are the latest concerns to impact health care in the black community. As the numbers reflect, this is a growing epidemic and the future outlook is not bright without a discovery of a vaccine and/or cure. The Afro-American community must come to grips with the fact that this is not a "gay white man's disease only" and begin to take steps to change sexual and drug use behavior therefore reducing risk.

The health problems facing the Afro-American community are multi-faceted as previously described, but the common threads are poverty and education. The facts clearly show that blacks are in the minority in terms of population but in the majority - over represented - for the health issues discussed in this paper. Medical care alone will not solve the problems. The solutions lie in government policies, community action and individual responsibility.

> The founding fathers of this country
> cited life, liberty and the pursuit
> of happiness as inalienable rights
> for each citizen. Yet, the quality
> of life - a healthy life - is, in the
> 1990's, still not assured for far too
> many black Americans.(18)

RECOMMENDATIONS: THE FUTURE

In order for the Afro-American community to be a viable resource for future mobilization immediate action must be taken to achieve long term results. Systemic problems in the black community that were identified during this research effort were: poverty, education, access to health care, and the lack of minority health care professionals. The following recommendations will attempt to frame the solutions for addressing the health care issue - and related problems - and encompass the involvement of Congress, the federal government, the community and most importantly, the individual.

CONGRESS

Congress must ensure that quality health care is available for everyone, regardless of income - a universal health care plan. The overall approach must be one of prevention in dealing with this awesome task.

- **Funding**

* Require states to remove dollar limits on Medicaid to make health care accessible to the poor and working poor. Remember, Medicaid is a public assistance program managed by the state government. Congress must close the gap between Medicaid and private insurance.

* Target select groups for special services with specifically tailored programs to correct deficiencies; i.e., prenatal care in the black community, high incidents of drug abuse in the inner city.

** Require states to keep more detailed information on victims and perpetrators, relationship and circumstances in order to get to the root cause of the problem.

* Enforce equal standards and nondiscrimination provisions for all providers of health services.

* Review anti-trust laws to ensure that they don't prohibit health care providers - researchers, hospitals, and doctors - from working with others that could possibly result in reducing cost by cutting duplication and independent efforts in technology research.

* Increase funding for programs already in place (see Appendix), which only scratches the surface of organizations and programs available.

- Education

* Provide funding for historically black medical schools and for those individuals in need at both the collegiate and medical school level. The majority of physicians working in minority communities are minorities and they can better relate to and identify with the people they are serving.

* Enforce as a prerequisite to funding, adherence to affirmative action in medical school admission and faculty hiring decisions.

* Tie education loans to community service.

* Encourage states to set up in-school health clinics and provide preventive medical education. Education must be continuous in the community, starting as early as possible.

FEDERAL GOVERNMENT

Within the federal government there are only two departments capable of taking the lead and making a significant difference in dealing with the health care issues in the Afro-American community and they are:

- o Department of Defense (DOD)
- o Department of Health and Human Services (DHHS)

- Department of Defense

The department's primary concern is for the health and welfare of its members - active, reserve and retired. In order for DOD to play a larger role, the mission of the services must be readdressed - enlarge the focus from just warfighting to reconstitution.

* Develop a program that allows minority members of the department to serve as "Role Models" in the community.

* Expand the Junior Reserve Officer Training Corps (JROTC) programs in the schools with emphasis on responsibility, discipline, and accountability.

* Direct reserve and national guard units performing their summer (active duty) training, to specific communities rather than to training sites in isolated areas.

* Create a separate civil budget funding line for health care similar to the way the Corps of Engineers have a separate line for civil affairs.

- Department of Health and Human Services

This department has the overall responsibility for health related issues in the United States, as the name implies. It is the interface agency between the federal government and state and local governments. The following are recommended actions for this department:

* Aggressively pursue current proven programs.

* *Use targeted programs in areas* where there is a known need, to include expanding health care services where data supports the underserved conditions.

* Work closer with state and local government to ensure health care is provided in a fair and timely manner by developing an effective quality control program.

* Develop future budgets that place emphasis on preventive medicine programs such as:

- Healthy Start
- Hot Breakfast and Lunch Programs
- Community Health Centers
- Housing Programs

It is necessary to first take care of the basic needs of individuals before dealing with larger issues.

* Dedicate more funding and priority to addressing the systematic problems associated with behavioral and social problems.

* Recruit more Afro-Americans into the policy-making level of the department.

* Aggressively recruit minorities for the DoD's Medical School.

COMMUNITY

The community consists of employers, the churches, the schools, local organizations and leaders, and family. Any
long-term effective solution must include the above list of components that can and must provide mutual support.

* Build coalitions and networks that address health issues, political issues and economic issues.

* Enhance individual awareness through education programs tailored for the community.

* Become involved in promoting good health and preventive health care.

* Ensure that those individuals, to include children who qualify for health care programs, make themselves available for the service.

* Employers must assist in closing the gap between those with health care coverage and those without health care coverage, by providing individual insurance or a group plan to include families.

* Develop methods of recruiting students for the medical career field.

* Support the development of programs that prepare Afro-American students for professional careers in medicine, science, business and the military.

* Develop local internal transportation systems for those who need it.

* Become politically and socially involved.

* Develop programs that teach self-worth, confidence, discipline, and a positive attitude.

INDIVIDUALS

The individual is the key player in determining the success or failure of any current or future programs. He/she must:

* Become an active participant in the system and take advantage of programs available.

* Become better educated, i.e., complete high school as a minimum.

* Be held accountable and responsible for their actions.

* Change behavior and sometimes lifestyles.

The above recommendations are not intended to be a panacea for the problems in the black community, but a significant step on the road of recovery. If implemented, the recommendations will ensure that resource will be available for mobilizing, in the black community, when required.

APPENDIX

Federal Resources

OFFICE OF MINORITY HEALTH RESOURCE CENTER

Answers requests from consumers and professionals on racial and ethnic minority health: issues, risk factors, resources, and programs.

FAMILY LIFE INFORMATION EXCHANGE

Distributes materials on family planning, adolescent pregnancy, and adoption. Primarily serves Title X and Title XX clinics.

OFFICE OF ADOLESCENT PREGNANCY PROGRAMS

Provides information on adolescent pregnancy teenage sexual activity, and federally funded programs prevention.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

Distributes consumer materials on a variety of topics including prenatal care, pregnancy and childbirth, and premature birth. Professional information is available on topics such as sudden infant death syndrome, pregnancy and perinatology, and contraception.

NATIONAL SUDDEN INFANT DEATH SYNDROME INFORMATION CLEARINGHOUSE

Offers information for consumers and professionals on sudden infant death syndrome (SIDS), infantile apnea, and death and grieving.

NATIONAL CENTER FOR EDUCATION IN MATERNAL AND CHILD HEALTH

Provides comprehensive information on maternal and child health issues including information on prenatal care, infant mortality, and adolescent pregnancy.

AIDS INFORMATION RESOURCES/NATIONAL AIDS INFORMATION CLEARINGHOUSE

Maintains an in-house database of educational materials and communications research related to AIDS. Information specialists can help requesters locate materials targeted to specific audiences and on specific aspects of AIDS.

MINORITY SUBSTANCE ABUSE PREVENTION PROJECT

Provides on-site technical assistance and regional training workshops to ethnic minority groups active in alcohol and drug abuse prevention.

NATIONAL CLEARINGHOUSE FOR ALCOHOL AND DRUG INFORMATION

Provides consumer and professional information on alcohol and drug use and abuse. Special information is available on substance abuse among minorities.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHP) NATIONAL HEALTH INFORMATION CENTER

Provides referrals to health organizations, including those concerned with racial and ethnic minorities.

FOOD AND DRUG ADMINISTRATION

Provides up-to-date information on the results of Federal and privately sponsored clinical trials of AIDS drugs and vaccines.

CENTERS FOR DISEASE CONTROL (CDC)

Publishes the monthly HIV/AIDS Surveillance, which includes tables giving numbers of AIDS cases to date, broken down by race/ethnicity and other categories.

Source: Department of Health and Human Services Office of Minority Health

END NOTES

1. General Colin L. Powell, Chairman of the Joint Chiefs of Staff, Convocation Ceremonies, Prairie View A&M University, Prairie View, Texas, 31 October 1990.

2. Harold J. Clem, Mobilization Preparedness, National Defense University Press, Washington, D.C., 1983. p.1.

3. Mike King, "Health Care for Blacks Criticized," Atlanta Constitution, 13 January 1989.

4. Farley and Reynolds, "The Quality of Life for Black Americans Twenty Years after the Civil Rights Revolution," The Milbank Quarterly, 1987, Volume 65, Department Sociology Population Studies Center, University of Michigan, Anne Arbor.

5. Louis W. Sullivan, M.D., Secretary of Health and Human Services, National Newspaper Association Annual Government Affairs Conference, Washington, D.C., 14 March 1991.

6. Bennett, L. The Shaping of Black America, 1975, Chicago: Johnson.

7. Haynes, M.A. (1984, June 7). Presentation to the Task Force on Black and Minority Health, DHHS. p. 1-3.

8. Louis W. Sullivan, M.D., Secretary of Health and Human Services, Before the Kennedy Political Union, The American University, Washington, D.C., December 12, 1990.

9. Leigh, W.A. A Health Assessment of Black Americans - A Fact Book. Joint Center for Political and Economic Studies, Washington, D.C. 1992. pgs. 5,10,13,39,40,49

10. Cheney, Dick, Secretary of Defense, Annual Report to the President and the Congress. GPO: Washington, D.C., February 1992. p. 46

11. Department of Defense, Defense 92 Almanac, GPO: Washington, D.C., September/October 1992. p.24

12. Purdom, Walton. Environmental Health, Orlando, Florida Academic Press, 1980. Ch. 1.

13. Braithwaite, Ronald, Dr., Atlantic Constitution, 13 January 1989, "Health Care for Blacks Critized. p. 1A

14. U.S. Bureau of the Census (1989a). Household and family characteristics, March 1988. Currennt Population Reports (Series P-20, No. 437). Washington, D.C. US GPO.

15. U.S. Department of Health and Human Services (1991a). Caring for our future. Hyattsville, Maryland. Public Health Service.

16. Monthly Vital Statistics Report, Vol. 40, N.8(S)2 January 7, 1992.

17. Braithwaite, Ronald L. and Taylor, Sandra E., Health Issues in the Black Community, Jossey-Bass, Inc., San Francisco, Cal. 1992. p.9.

18. U.S. Department of Health and Human Services (1989). Health Status of Minorities and Low-Income Groups: Third Edition. Hyattsville, Maryland. Public Health Service.

19. U.S. Department of Commerce Economics and Statistics Administration Statistical Abstract of the United States 1991- The National Data Book, Bureau of the Census.

20. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Minority Health. Closing the Gap-Homicide, Suicide, Unintentional Injuries, and Minorities, U.S. GPO 1990.

21. Bell, Carl C., M.D. with Jenkins, Esther J., Ph.D., The State of Black American 1990 Preventing Black Homicide National Urban League, Inc.

22. U.S. Department of Health and Human Services, Public Health Services, Office of the Assistant Secretary for Health, Office of Minority Health. Closing the Gap-AIDS/HIV Infection and Minorities U.S. GPO 1990.

TABLE REFERENCES

TABLES	REFERENCES	
1, 2, 3, 5, 6, 10	Leigh, W. A.	A Health Assessment of Black Americans- A Fact Book. Joint Center for Political and Economic Studies, Washington, D. C. 1992.
4, 12	Braithwaite, Ronald, Dr.	Atlantic Constitution, 13 January 1989, "Health Care for Blacks Critized.
7, 8, 9		Monthly Vital Statistic Report - Vol. 40, No. 8(S) 2, January 7, 1992.
11		U. S. Department of Commerce Economics and Statistics Administration Statistical Abstract of the United States 1992 - The National Data Book, Bureau of the Census.